Bac g d

Non-communicable diseases (NCDs) and their risk fac-

gaps and illuminated the policy development processes and actors involved. Each country team reviewed global and national policy documents with a particular emphasis on information for the sub-Saharan Africa region.

implementation. These global commitments are expressed through various policy documents such as the WHO Framework Convention on Tobacco Control (FCTC) of 2003 [17], WHO Global Strategy on Diet, Physical Activity and Health of 2004 and the WHO strategy to reduce harmful alcohol consumption initiated in 2008 and endorsed in 2010 [18, 19

other countries, NGOs and community organizations played lobbying or assistive roles.

Consultations and stakeholder engagement

The findings from the study countries reveal that most of the NCD prevention policies were developed through a consultative process with various stakeholders, some of whom were from other sectors. The health sectors hosted several workshops and meetings with relevant stakeholders working in the risk-factor area. In many instances, small working groups formed to draft the policy documents which were then shared with other stakeholders for input.

Tab e 2 Implementation of tobacco and alcohol control interventions

Best buy interventions	Interventions implemented	Country				
		Cameroon	Kenya	Malawi	Nigeria	South Africa
Tobacco						
Taxation	Taxation on all cigarettes	Yes	Yes	Yes	No	Yes
	Increase in tobacco taxes since 2011	Yes	Yes	–	No	Yes
	Tax applies to all tobacco products (cigarettes, snuffs, chewing tobacco)	Partial	–	Partial	No	Yes

companies still advertise in non-regulatory zones, such as on the walls of alcohol-serving establishments in some regions.

All countries restrict sale of alcohol to children under 18, but it is not clear the extent to which this is actively enforced and monitored. Kenya has been implementing regulation to restrict opening hours and points of sale in the supermarkets. Cameroon has prohibited alcohol use in schools and has bans on opening drinking spots within or near schools. Kenya, Malawi and South Africa are enforcing licensing of alcohol, while Cameroon has only implemented this partially. Kenya has reduced alcohol advertising times from 8.30 pm on TV and from 2 pm on radio. Malawi has restrictions on alcohol advertising but not complete bans, while Cameroon has restrictions on content of advertisements but no ban of alcohol advertising. South Africa has no legal restrictions relating to advertising liquor products. These existing restrictions on liquor ensure only that there is a limited underage exposure to alcohol advertisement such as restricting time in which television alcohol adverts may be shown. Except for Nigeria, all countries have some tax on alcohol products. In South Africa, alcohol taxation for beer is 35% and for spirits is 48%. Kenya has excise taxes on alcoholic products, but the figures were not readily available. Cameroon raised alcohol taxes in

While comprehensive policies for tobacco (apart from Malawi) and alcohol (apart from Nigeria) have been fully developed in most of the countries, both diet and physical activity policies addressing the WHO "best buy" interventions have been less prioritized. South Africa is the only country that has made progress in addressing nutrition and diet "best buy" interventions. This could be because of better political system and availability of evidence on the effects of high salt consumption on health [22].

The actual formulation process for most of the policies appears to have been consultative with engagement of various stakeholders. However, broad consultation and participation of diverse sectors seems not to be well entrenched in actual formulation and implementation of policies, such as the nutrition-related measures. In most cases, relevant stakeholders are engaged through several workshops and meetings to address a specific risk factor area. It is evident from the study countries that such stakeholder engagements are not well documented and lacked continuity, which might have resulted in inconsistency in sectorial engagement. In other reviews, engagement of multiple sectors and actor in policy development has been hindered by lack of clear national mechanisms for multi-sectoral coordination and engagement [16].

The findings reveal disparities in implementation of most of the NCD "best buy" interventions in terms of both processes and timing. Although policy agendas for some risk factors emerged in the 1960s, most of the comprehensive policy documents are recent and so implementation is not yet comprehensive, e.g., in alcohol control policies in Nigeria and Malawi, nutrition action plans in all countries and the recently developed NCD strategic plans. Some of these policies were being completed at the time of data collection. In addition, most of the interventions under implementation are either partially implemented or not implemented. The implementation gaps observed in the case studies include lower geographical coverage and in some instances failure to put enforcement measures in place. All the countries exhibit poor enforcement and compliance with the laws related to tobacco and alcohol control policies. Strategies for monitoring implementation also seem not be clear in all countries despite the presence of these policies. Weak monitoring systems could lead to poor measurement of policy impacts on the population.

The major challenge to policy formulation and implementation cited by all countries was lack of funding particularly from the government. While there has been high global political commitment to NCD prevention, the same cannot be said of the in-country political will. Inadequate political will was shown by insufficient resources to NCD prevention or even to put in place the right policies, resulting in slow policy formulation processes in some countries. One of the reason for failure to allocate resources for NCDs could have been a perception of a lower priority for NCD in the past given the other health priorities in the countries. NCDs have been assumed to be lifestyle disease that people can prevent by themselves. Another reason could be lack of knowledge of the magnitude and impact of NCD risk factors high level decision makers. Global funding for NCDs is also very low compared to funding given for other areas like HIV/AIDs, Tuberculosis, Malaria and Maternal Health [23]. Studies from other LMIC have reported similar challenges to NCD policy development and implementation. For instance, in Indonesia and Uganda challenges to NCD policy process include insufficient political interest in NCD control, low resource capacity, poor monitoring and evaluation mechanism and difficulty in multi-sectoral coordination [24, 25]. NCD interventions cannot be implemented without addressing these gaps in policy process [5].

There seems to have been heavy reliance on NGOs to support certain aspects of policy formulation and implementation, yet NGOs have a narrow scope of interventions that they can support at a time given the low global funding. The funding challenge is compounded by the fact that implementing institutions, NGOs and other entities often do not seem to be pooling resources to implement activities. Thus different, sometimes duplicative, activities may take place without synergy and complementarity, thus leading to disjointed policy-making and implementation. The end result is inadequate implementation/reinforcement of the existing laws. Enforcement of these laws requires more resources for operational activities and capacity building implementing personnel.

Another significant challenges was industry interference with the policy process. Tobacco, alcohol and sugary drink industries which are major risk factors for NCDs have often interfered with health policy through

"

review and address the gaps in the existing NCD prevention policies and accelerate implementation of the most effective interventions in all the countries. This will require strong political commitment within countries and support for stronger coordination and en-